STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 01 B. WING	12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	586 EASTERN BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/20/12 Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Riverview Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (111) construction and fully sprinklered.	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending December 20, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 106 at the time of this visit. All areas where residents have customary access were sprinklered except the first floor therapy room exit stairway nine foot by six foot overhang, the first floor Kitchen Hall exit stairway nine foot by six foot overhang, and the first floor A Hall stairway exit nine foot by six foot overhang. All areas providing facility services were sprinklered except the detached two story laundry building, the detached eight foot by thirty foot storage shed, the detached twenty foot by sixteen foot old smokers building, and five detached fourteen foot by twelve foot storage sheds. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the			

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observation and interview, the facility failed to ensure 1 of 8 attic smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 18 residents who reside on the second floor F Hall. Findings include: Based on observation with the maintenance supervisor and administrator on 12/20/12 at 12:45 p.m., the F Hall smoke barrier wall above smoke barrier doors had an eight inch area near the center of the smoke barrier wall with no drywall, a three inch circular area on the east side of the smoke barrier wall with no drywall, and a six inch by six inch	K0025	K 025NFPA 101 LIFE SAFETY CODE STANDARD requires thatSmoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The areas identified as concerns were repaired and replaced with approved fire-rated caulking including: A. An eight inch area, in the F Hall above smoke barrier doors, near the center of the smoke barrier wall. B. The three inch circular area, in	01/19/2013

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	area in the center of the smoke barrier wall filled with non rated yellow expandable foam. Based on an interview with the maintenance supervisor on 12/20/12 at 12:55 p.m., the yellow expandable foam is not a fire rated product. The F Hall missing drywall and non rated yellow expandable foam was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1-19(b) 2. Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 59 first floor room ceilings was constructed to provide at least a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 40 of 87 residents who would use the first floor dining room, next to the kitchen. LSC Section 8.3.6.1 requires the passage of building		the F Hall above the smoke barrier doors, on the east side of the smoke barrier wall. C. The six inch area in the center of the smoke barrier wall. D. The twelve inch by six inch area in the first floor elevator equipment room ceiling. E. Two, two inch by two inch areas of drywall missing in the first floor elevator equipment room. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K025 on Dec. 21st, 2012 by Administrator(See Attachment A). 4. The Administrator or designee will utilize the Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment B). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before January 19 th , 2013.	

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	service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 40 residents who use the main dining room, which is located near the elevator equipment room. Findings include: Based on observation on 12/20/12 at 9:45 a.m. with the maintenance supervisor and administrator, the first floor elevator equipment room ceiling had a twelve inch by six inch area and two, two inch by two inch areas of drywall missing. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1-19(b)			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 12 first floor hazardous areas, such as a fuel fired heater room, was provided with a smoke resistant door. This deficient practice could affect 40 residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 12/20/12 at 10:30 a.m. with the maintenance supervisor and administrator, the kitchen natural gas powered hot water heater room door failed to self close and was propped open sixteen inches by the door dragging on the	K0029	K 029 NFPA 101 LIFE SAFETY CODE STANDARDOne hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The door in the kitchen natural gas powered hot water heater room, which failed to self close, was repaired. 2. All residents have the potential to be affected. Facility inspected to	01/19/2013

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	concrete floor. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1-19(b)		ensure no further areas of concern. 3. Maintenance staff in-serviced on K029 on December 21st, 2012 by Administrator (See Attachment A). Dietary Staff will be in-serviced on or before January 19th, 2012 by Maintenance Director on K029.4. The Administrator or designee will utilize the Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment B). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before January 19 th , 2013.	

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K0056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 3 of 4 stairway exit overhangs were completely sprinklered. This deficient practice affects 8 residents who use the therapy room at a time, 40 residents who use the main dining room located near the first floor stairway exit below the second floor Maintenance Hall, and 19 residents who reside on the A Hall. Findings include: Based on observations on 12/20/12 during a tour of the facility with the maintenance supervisor and administrator from	K0056	K 056NFPA 101 LIFE SAFETY CODE STANDARDIf there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The areas identified as	01/19/2013

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	8:30 a.m. to 1:30 p.m., the first floor Kitchen Hall stairway exit overhang, the first floor therapy room stairway exit overhang, and the first floor A Hall stairway exit overhang, each measuring nine feet by six feet, were not provided with sprinkler coverage. This was verified by the maintenance supervisor and administrator at the time of observations and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1-19(b)		a concern will be equipped with the appropriate sprinkler system including; A. The first floor Kitchen Hall stairway exit overhang. B. The first floor therapy room stairway exit overhang. C. The first floor A Hall stairway exit overhang. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K056 on December 21st, 2012 by Administrator (See Attachment A). 4. The sprinkler system will be maintained as part of the Preventative Maintenance Program. 5. The above plan of correction will be completed on or before January 19 th , 2013.	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 outside overhangs was provided with sprinkler heads free of corrosion. 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 8 residents who use the activity bus at a time at the front entrance. Findings include: Based on observation on 12/20/12 at 12:10 p.m. with the maintenance supervisor and	K0062	K 062NFPA 101 LIFE SAFETY CODE STANDARD states that a required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The sprinklers identified as an area of concern on the front entrance outside overhang will be replaced. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K062 on December 21st, 2012 by Administrator (See Attachment A). 4. The Administrator or designee will utilize the Preventative Maintenance Monitoring Tool monthly to ensure compliance is maintained (See Attachment B). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before January 19, 2013.	01/19/2013

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	administrator, the front entrance outside overhang had six sprinklers completely covered with green corrosion. This was verified by the maintenance supervisor and administrator at the time of observation and confirmed by the administrator at the 1:30 p.m. exit conference on 12/20/12. 3.1-19(b)			